STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005033	A. BUILDING: _____ B. WING _____	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER REGIONAL HOSPITAL	85 EAST US HWY 6 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00153005 Substantiated: no deficiencies related to allegations are cited Date: 8/26/14 Facility Number: 005033 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor Porter Regional Hospital is in compliance with 410 IAC 15-1.5-2, Infection control, and 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: claughlin 09/05/14	S 000		